



**Patient Intake Form**

Version 2.1.1 | Document Code: INT-PAT-2025

Effective: 01 September 2025

**Patient Intake Form**

Patient Details													
Title		First Name											
Last Name													
Email Address													
Phone													
Date of Birth	D	D	M	M	Y	Y	Y	Y	Y	Y	Y	Y	AGE
ID Number													
Address													
Street Address													
City/ Town													
Postal Code													
Next of Kin Details / Legal Guardian/Parent Details (for patients U/18)													
First Name													
Last Name													
Phone													
Email Address													
Relationship to Patient													
Primary Account Holder (Person responsible for the account, <b>if same as Patient Details, leave open</b> )													
Title		First Name											
Last Name													
Email Address													
Phone													
ID Number													
Address													
Street Address													
City/Town													
Postal Code													
Medical Aid Details													
Medical Aid Name													
Plan Name													
Main Member													
Medical Aid Number													



Medical History				
Name of your GP				
GP Phone Number/Email				
<b>List any Serious Medical Conditions:</b>				
<b>List all Current Medications</b>				
<b>List all Allergies</b>				
<b>For Women</b>				
Are you currently pregnant	YES		NO	
If yes, how many weeks pregnant?				
<b>Consent and Agreement</b>				
I confirm that all the details above are accurate and that I will inform Dr O'Callaghan Dental Care of any changes when it may occur. I, the patient (or parent/legal guardian) accept responsibilities for payment, and acknowledge financial policies, as well as consent for treatment and privacy, including how personal data is collected and will be stored and used per the Protection of Personal Information Act 4 of 2013 (POPIA).				
Signature				
Date				
<b>FOR PRACTICE USE ONLY</b>				
<b>Patient File Number:</b>				
<b>Date of First Visit:</b>				